STATE OF HAWAII

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES PROSPECTIVE REIMBURSEMENT SYSTEM FOR INPATIENT SERVICES

I. GENERAL PROVISIONS

A. PURPOSE

This plan establishes a reimbursement system for acute care facilities which complies with the Code of Federal Regulations. It describes principles to be followed by Title XIX acute care providers in making financial reports and presents the necessary procedures for setting rates, making adjustments, and auditing the cost reports.

B. OBJECTIVE

The objective of this plan is to establish a prospective payment system that complies with the Omnibus Reconciliation Act of 1981, which requires that reimbursements be reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

C. REIMBURSEMENT PRINCIPLES

1. The Hawaii Medicaid Program shall reimburse Providers for inpatient institutional services based primarily on the prospective payment rates developed for each facility as determined in accordance with this Plan. In addition, certain costs (such as Capital Related Costs) shall be reimbursed separately. The estimated average proposed payment rate under this plan is reasonably expected to pay no more in the aggregate for inpatient hospital services than the amount that the Department reasonably estimates would be paid for those services under Medicare principles of reimbursement.

2. A hospital-specific retrospective settlement adjustment shall be made for those providers whose Medicaid charges are less than Medicaid payments on the cost report and do not qualify as nominal charge providers under Medicare principles of reimbursement.

3. Prospective rates shall be derived from historical facility costs, and facilities shall be classified based on discharge volume and participation in an approved Medical Education program.

4. Providers that average fewer than 250 Medicaid discharges per year shall be classified as Classification I facilities and shall receive All-Inclusive Rates, plus all appropriate Adjustments, (Section I.D.3). Capital Related Costs shall be reimbursed separately from the All-Inclusive Rates.

5. Providers which average 250 Medicaid discharges or more per year shall be separated into two facility classifications (Classifications II and III) and shall receive payment based upon the type of services required by the patient. Psychiatric services will be paid on the basis of an All-Inclusive Rate, plus all appropriate Adjustments, (Section I.D.3.). Nonpsychiatric claims will be designated as requiring either surgical, medical, or maternity care and will be paid on the basis of a routine per diem rate for the service type plus an ancillary per discharge rate for the service type, plus all appropriate Adjustments, (Section I.D.3.). Capital Related Costs shall be reimbursed separately from the per diem and per discharge rates.

6. The freestanding rehabilitation hospital shall be excluded from Classifications I, II, and III and designated as Classification IV, and shall receive payment based on All-Inclusive Rates, plus all appropriate Adjustments, (Section I.D.3.). Capital Related Costs shall be reimbursed separately from the per diem and/or per discharge rates.

D. DEFINITIONS APPLICABLE TO THE PROSPECTIVE RATE SYSTEM

The following definitions shall apply for purpose of calculating prospective payment rates and adjustments for acute inpatient services:

1. "Acuity Level A" means that the Department has applied its standards of medical necessity and determined that the Resident requires a level of medical care from a Nursing Facility relatively lower than Acuity Level C. Prior to October 1, 1990, that level of care was appropriately obtained from an ICF.

2. "Acuity Level C" means that the Department has applied its standards of medical necessity and determined that the Resident requires a level of medical care from a Nursing Facility relatively higher than Acuity Level A. Prior to October 1, 1990, that level of care was appropriately obtained from an SNF.

3. "Adjustments" mean all adjustments to the Basic Per Diem, Basic Per Discharge and All-Inclusive Rates and/or the Capital Payments that are defined in this Plan and that are appropriate for a particular Provider. Those adjustments may include the ROE/GET Adjustment, the Medical Education Adjustment, and/or the Severity and Case Mix Adjustment.

4. "All-Inclusive Rates" means the separate per diem rates that are paid to Classification I and IV facilities for psychiatric and nonpsychiatric cases, and the per diem rates that are paid to Classification II and III facilities for psychiatric cases only. The All-Inclusive Rates are calculated to include reimbursement for both routine and ancillary costs.

5. "Ancillary Services" means diagnostic or therapeutic services performed by specific facility departments as distinguished from general or routine patient care such as room and board. Ancillary services generally are those special services for which charges are customarily made in addition to routine charges, and they include such services as laboratory, radiology, surgical services, etc.

6. "Base Year" means the State fiscal year used for initial calculation and recalculation of prospective payment rates. The Base Year shall be the most recent State fiscal year or years for which complete, finally-settled financial data is available. Base Year data shall be supplemented with finally-settled cost data from previous years, if it is determined that extraordinary costs occurred in the most recent, finally-settled cost report.

7. "Breakeven Point" means the point at which a hypothetical Special Care Percentage in the Base Year would not have resulted in the elimination of any costs due to the application of the ceiling factors in calculating the PPS rates.

8. "Basic Per Diem Rate" means the applicable per diem amount for each Provider for each category of care, as calculated pursuant to the methodology defined in this Plan. It does not include the various adjustments to that basic per diem rate defined in this Plan.

9. "Basic Per Discharge Rate" means the applicable per discharge amount for each Provider in Classifications II and III for each category of care, as calculated pursuant to the methodology defined in this Plan. It does not include the various adjustments to that basic per diem rate defined in this Plan.

10. "Capital Payment" means the payment in addition to the All-Inclusive, Basic Per Diem and Basic Per Discharge Rates to compensate a Provider for Medicaid's fair share of the Provider's Capital Related Costs.

11. "Capital Related Costs" means costs associated with the capital costs of the provider's facilities and equipment under Medicare principles of reimbursement. For purposes of the prospective payment methodology, Capital Related Costs shall include depreciation, interest, property taxes, property insurance, capital leases and rentals, and costs and fees related to obtaining or maintaining capital related financing.

12. "Claim Charge Data" means charges and other information obtained from billing claim forms processed by the Medicaid fiscal agent.

13. "Costs" means total finally-settled allowable costs of acute inpatient services, unless otherwise specified.

14. "Discharge" means the release of a patient from an acute care facility. The following events are considered discharges under these rules:

a. The patient is formally released from the hospital.

b. The patient is transferred to an out-of-state hospital.

c. The patient is transferred to a long-term care level or facility.

d. The patient dies while hospitalized.

e. The patient signs out against medical advice.

f. In the case of a delivery where the mother and baby are discharged at the same time, the mother and her baby shall be considered two discharges for payment purposes. In cases of multiple births, each baby will be considered a separate discharge.

g. A transfer shall be considered discharge for billing purposes but shall not be reimbursed as a full discharge except as specified in Section IV.B.6.a.

15. "Federal PPS" means the prospective payment system based upon diagnostic related groups ("DRGs") used by the Medicare program under Title XVIII of the Social Security Act to pay some hospitals for services delivered to Medicare beneficiaries.

16. "Inflation Factor" means the estimate of inflation in the costs of providing hospital inpatient services for a particular period as estimated in the DRI McGraw-Hill Health Care Costs: National Forecast Tables, PPS-Type Hospital Market Basket, or its successor.

17. "Inpatient" means a patient who is admitted to an acute care facility on the recommendation of a physician or dentist and who is receiving room, board, and other inpatient services in the hospital at least overnight, and requires services that are determined by the State to be medically necessary. A patient who is admitted to an acute care facility and expires while in the facility shall be considered an inpatient admission

regardless of whether the stay was overnight. Emergency room services are included in the PPS inpatient rate only when a patient is admitted from the emergency room.

18. "Medical Education" means direct costs associated with an approved intern and resident teaching program as defined in, the Medicare Provider Reimbursement Manual, HCFA Publication 15-I, Section 404.1.

19. "Medical Education Adjustment" (Section III.D.5.), means the adjustment to the All-Inclusive, Basic Per Diem and Basic Per Discharge Rates to compensate a Provider for Medicaid's fair share of the expenses of participating in medical education.

20. "New Provider" means a Provider that began operations before January 1, 1993, but does not have a cost report in the Base Year that reflects at least a full twelve months of operations.

21. "Nonprofit Provider" means a Provider that is organized as a nonprofit corporation and is generally exempt from state general excise and federal income taxes.

22. "Operating Year" means the twelve consecutive month period beginning on the latest of the following dates:

    a. July 1, 1990; or

    b. The date that a hospital becomes a Provider.

23. "Outlier Claim" means any claim which has total charges in excess of the Outlier Threshold, provided, however, that an Outlier Claim does not cease to have that status by reason of a subsequent increase in the Outlier Threshold.

24. Outlier Threshold" means $35,000 increased by the cumulative Inflation Adjustment since the state fiscal year ending June 30, 1987; provided, however, that the Department may round the figure to the nearest thousand dollars. For the state

fiscal year beginning July 1, 1994, the Outlier Threshold is $53,000.

25. "Outpatient" means a patient who receives outpatient services at a hospital which is not providing the patient with room and board and other inpatient services at least overnight. Outpatient includes a patient admitted as an inpatient whose inpatient stay is not overnight, except in cases where the patient expires in the facility.

26. "PPS" means the prospective payment system that is established by this Plan.

27. "Plan" means this document.

28. "Proprietary Provider" means a Provider that is organized as a for-profit entity and is subject to state general excise and federal income taxes.

29. "Provider" means a qualified and eligible facility that contracts with the Department to provide institutional acute care services to eligible individuals.

30. "Rebasing" means calculating the Basic PPS Rates by reference to a new Base Year and new Base Year Cost Reports.

31. "ROE/GET Adjustment" means the adjustment to the All-Inclusive, Basic Per Diem and Basic Per Discharge Rates to provide Medicaid's fair share of a return on the investment that a Proprietary Provider has made in its facility and for Medicaid's fair share of the general excise taxes that it pays the State of Hawaii, as calculated under this Plan.

32. "Routine services" means daily bedside care, such as room and board, serving and feeding patients, monitoring life signs, cleaning wounds, bathing, etc.

33. "Severity and Case Mix Adjustment" means an increase of 2% to the All-Inclusive Rate of the Classification IV facility.

34. "Special Care Percentage" means the result of dividing the Medicaid special care days for a given cost reporting period by the total Medicaid days for the same period. The days reported in the nursery cost center on the cost report shall be excluded from the calculation.

35. "Total All-Inclusive Rate" means the All-Inclusive Rate plus all appropriate Adjustments, (Sections III.D., III.G., and IV.A.), to that rate for a particular Provider that are defined in this Plan. The Total All-Inclusive Rate is the result of multiplying the following components of the total rate for each Provider or category of payments that has an All-Inclusive Rate:

(All-Inclusive Rate)
(ROE/GET Adjustment [if applicable])
(Medical Education Adjustment Factor [if applicable])
(Severity and Case Mix Adjustment)
[if applicable])
(cumulative Inflation Factor)

36. "Total Per Diem Rate" means the Basic Per Diem Rate plus all appropriate Adjustments, (Sections III.D., III.G., and IV.A.), to that rate for a particular Provider that are defined in this Plan. The Total Per Diem Rate is the result of the multiplying the following components of the total rate in each category for which the Provider has a Basic Per Diem Rate:

(Basic Per Diem Rate)
(ROE/GET Adjustment [if applicable])
(Medical Education Adjustment Factor [if applicable])
(cumulative Inflation Factor)

37. "Total Per Discharge Rate" means the Basic Per Discharge Rate plus all appropriate Adjustments, (Sections III.D., III.G., and IV.A.), to that rate for a particular Provider that are defined in this Plan. The Total Per Diem Rate is the result of multiplying the following components of the total rate in each category for which the Provider has a Basic Per Diem Rate:

(Basic Per Discharge Rate)
(ROE/GET Adjustment [if applicable])
(Medical Education Adjustment Factor [if applicable])
(cumulative Inflation Factor)

38. "Waitlisted patient" means a patient who no longer requires acute care and is awaiting placement to a long-term care facility.

E. SERVICES INCLUDED IN THE PROSPECTIVE PAYMENT RATE

The prospective payment rate shall include all services provided in an acute inpatient setting except:

1. Professional component, including physician services or any other professional fees excluded under Part A Medicare;

2. Ambulance; and

3. Durable medical equipment (except for implanted devices) that the patient takes home after he or she is discharged.

II. PREPARATION OF DATA FOR PROSPECTIVE PAYMENT RATE CALCULATION

A. SOURCE

1. The calculation of prospective payment rates shall be based on facility-specific claims and cost data, as follows:

   a. Cost data shall be abstracted at the time the rate calculation begins from finally-settled uniform cost reports submitted to the Department by each Provider in accordance with federal Medicaid requirements.

   b. The cost report used for each facility shall be the facility's report which ended during the state fiscal year selected as the Base Year.

   c. Supplemental costs reporting forms submitted by providers shall be used as necessary. Claims data shall be derived from claims

submitted by Providers for Medicaid reimbursement.

d. For Rebasing, the latest available claims data for a two fiscal year period shall be used. Claims that are paid by December 31 of the year following the year in which the last fiscal year included in the data collection effort ends shall be considered as a paid in the fiscal year when the service was rendered.

2. Additional cost data supplied by Providers shall be utilized to update cost data only as specified in this plan. For Rebasing, Providers will be given an opportunity to submit cost data similar in nature to that included in the TAC cost reports, excluding Capital Related Costs.

3. Inflation in the costs of delivering Inpatient hospital services shall be recognized by using the Inflation Factor (Section I.D.24.). The Inflation Factor shall be used both to update the historical costs of delivering services and to project future increases in those costs.

B. CLASSIFICATION OF ACUTE INPATIENT FACILITIES

1. For purposes of establishing the PPS rates, acute Inpatient facilities shall be classified into the following four mutually exclusive groups:

a. Classification I - Facilities averaging less than 250 Medicaid discharges per year;

b. Classification II - Facilities averaging 250 Medicaid discharges per year or more, which do not participate in approved intern and resident teaching programs;

c. Classification III - Facilities averaging 250 Medicaid discharges per year or more which participate in approved intern and resident teaching programs; and

d. Classification IV - The freestanding rehabilitation hospital.

SECTION 4. Section 235-55.9, Hawaii Revised Statues, is amended by amending subsection (f) to read as follows:

"(f) If the tax credit [is] claimed by an individual includes qualified medical expenses calculated at the rate of four and one-half per cent, and the individual resides in a county in which the county general excise and use tax surcharge is not in effect, or if the tax credit that includes qualified medical expenses calculated at the rate of four and one-half per cent is claimed in a county [which] that has a county general excise and use tax surcharge in effect by an individual who has resided in that county for not more than two hundred days of the taxable year in the aggregate, there shall be added to and become part of the tax liability of the individual:

(1) The amount of the tax credit claimed under this section multiplied by three; or
(2) Ten per cent of the income tax liability for the taxable year for which the individual income tax return is being filed,

whichever is greater.

All claims for tax credits under this section, including any amended claims, must be filed on or before the end of the twelfth month following the close of the taxable year for which the credits may be claimed. Failure to comply with the foregoing provision shall constitute a waiver of the right to claim the credit."

SECTION 5. The department of human services shall submit a report to the legislature no later than twenty days prior to the convening of the regular sessions of 1994 and 1995, respectively, which shall include, but is not limited to, the following:

(1) The status of the provider tax, including the revenues realized from each facility, and any Medicaid reimbursements provided to these facilities;
(2) An accounting of federal matching funds drawn down from the reimbursement rate resulting from the provider tax; and
(3) An update of the administrative costs, and staffing required to carry out the purposes of this Act.

SECTION 6. There is appropriated out of the general revenues of the State of Hawaii the sum of $125,000, or so much thereof as may be necessary for fiscal year 1993-1994, to carry out the purposes of this Act, including the hiring of necessary staff. The sum appropriated shall be expended by the department of human services.

SECTION 7. Statutory material to be repealed is bracketed. New statutory material is underscored.

SECTION 8. This Act, upon its approval, shall:

(1) Take effect on July 1, 1993, or the effective date of reimbursement changes referred to in section -14 of section 1 of this Act, whichever is later; and
(2) Apply to hospital and nursing facility income arising from activities occurring on and after the effective date of this Act and before July 1, 1995.

(Approved June 21, 1993.)